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MEDICAID MANAGEMENT INFORMATION SYSTEM,

GENERAL SYSTEMS DESIGN FOR TITLE XIX

VOLUME III, SURVEILLANCE AND UTILIZATION REVIEW SUBSYSTEM

REVISION: 29 SEPTEMBER 1982

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MEDICAID

MANAGEMENT INFORMATION SYSTEM

GENERAL SYSTEMS DESIGN

FOR TITLE XIX

VOLUME III: SURVEILLANCE AND UTILIZATION REVIEW SUBSYSTEM

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
BUREAU OF PROGRAM OPERATIONS
OFFICE OF METHODS AND SYSTEMS
DIVISION OF SYSTEMS PLANNING AND DEVELOPMENT

Please make the following additions to the Revised 29 September 1982 edition of Volume III (S/URS) MMIS-GSD.

Insert the attached "FORWARD" page in between the title page and the ACKNOWLEDGMENT page.

Replace the following:

Page VI-ii, Table of Contents

Page VI-7

FORWARD

The 29 September 1982 revised edition of the Surveillance and Utilization Review Sybsystem (S/URS) of the Medicaid Management Information System, General Systems Design (MMIS-GSD) is an addendum to Volume III of the MMIS-GSD. The document represents a composite view of State experiences in the surveillance and utilization review processes. The revised S/URS includes systems enhancements based on the State S/UR operating experiences, reduces the reporting burden on States, and provides systems options that are directed at the overall improvement in S/UR methodologies. States are encouraged to review their surveillance and utilization review processes using the revised S/URS-GSD as a basis for the review and determine where specific system improvements can be made in their unique S/UR operations. The applicable Federal approval requirements for systems improvements and enhancements apply as cited in Chapter 2, Part 11 of the State Medical Manual.

SECTION VI

SURVEILLANCE AND UTILIZATION REVIEW

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B. DESIGN ELEMENTS

The design elements for S/URS have been separated into primary and secondary categories, where primary considerations contain minimally required features and secondary considerations contain a group of options. Additional considerations are not precluded and should be addressed during the early phase of the design effort.

1. Design Constraints and Assumptions

This subsystem is largely constrained by the nature of information made available to it through the vehicle of adjudicated claims. The existence of the Model System Claims Processing, Provider, and Recipient Subsystems or their equivalents are assumed. It is also assumed that claims will not be forced through prepayment edits in claims processing (forced or override codes cause data distortion). This will assure the integrity of the S/URS data base.

2. Design Considerations

a. The Surveillance and Utilization Review Subsystem is a flexible management tool which can help identify patterns of inappropriate care and services. The screening function of S/URS is implemented through an automated exception processing technique. Conceptually, the exception processing technique requires the following major steps to be performed by the computer system:

- Develop statistical profiles summarizing information contained in paid claims submitted by each individual and institutional provider over a specified period of time. Each profile will consist of a number of statistical indicators which relate to services rendered or received and which include the cost of those services;

- Classify providers and recipients into class groups of peers for the purpose of developing statistical profiles;

- Compute averages and standard deviations by class group for each indicator contained within each statistical profile. Only those individuals with indicators where the activity does not contain a zero value are taken into consideration for these computations;

- Establish norm and exception criteria values by class group for each indicator in the statistical profile from averages and standard deviations computed in the previous step and/or from user specified exception criteria which can override a systems generated norm;

- Evaluate the statistical profiles of all individual providers or recipients within each class group (indicator by indicator) against the matching exception criteria established by user groups for each class group; and

- Print out for manual review a ranking of providers and recipients who were found to be exceptional. At this point, the Medicaid activity for each individual provider and recipient has been evaluated against the mean activity of the group of his peers and is presented for further investigation only if the exception parameters have been surpassed.

b. The functions of peer group classifications and establishment of group norms are statistically determined in the early stages of the system's installation. After the system has been stabilized and tailored to fit the particular circumstances of its user, adjustments can be made to compensate for further changes in the Medicaid environment.

c. The scope of the S/URS activity is completed with the following additional functions which are based on information developed by the exception reporting process:

- Investigate suspected misutilization by examination of adjudicated claim histories and remittance notices sometimes followed by desk audits, field audits, and peer review;

- Produce a permanent microform (e.g., film, fiche) of the periodic profiles of excepted participants. From this microform record, up-to-date and historical information may be obtained on any Medicaid participant for whatever uses may be required;

- Determine actual aberrant utilization;

- Evaluate aberrancies to determine if fraudulent conditions exist;

- Initiate actions to close identified loopholes in the computer system, policy issuances, rules, and regulations so as to prevent further misutilization within the program; and

- Initiate appropriate corrective action against actual abusers according to the nature of their abusive activities and practices.

d. In summary, the computer can assist in the manual functions of investigation and follow-up action to isolate and highlight the small number of misutilizers from the thousands of Medicaid participants. The S/URS maintains participant information and all essential data from adjudicated claims to accomplish this primary goal. The claims data may be selected and printed, at the request of the user, in such a way that only information which is of value in making a determination of misutilization is displayed for the user.

At a minimum, S/URS must include:

- the capability to perform exception processing as identified above;

ACKNOWLEDGMENT

Many Individuals contributed to this effort, both directly and indirectly, and at many levels within selected States and Federal Offices. Appreciation is expressed to Mr. Robert Nakamoto, Mr. Nelson Berry, Ms. Patricia Wright, Mr. George Padgett and Miss Toian Vaughn, Division of Systems Planning and Development; Mr. Gerald Schonberger, Region III, Mr. Kee Chang, Dr. Mike Nelson, and Mr. Joseph Piazza, Office of the Inspector General; Mr. Daniel Boyle and Mr. Joseph Bruno, Corrective Action Projects Division; Mr. Thomas Gaylord, Minnesota Bureau of Surveillance and Utilization Review (S/UR); Ms. Bernice Koski, Ohio Bureau of S/UR; Mr. Charles Beaty, Georgia Bureau of S/UR; Ms. Joan Fosler and Mr. Chung Shin, Bureau of Quality Control; Mr. Robert Harrison, Office of Program Validation; and Dr. Gerald Zelinger, Professional Standards and Review Organization.

The integrity of this document has been significantly enhanced by the cooperation provided during on-site visits to several States. Appreciation is experessed to these Program Managers and their staffs as follows: Dr. Robert Levin and staff of the Michigan Department of Social Services; Mr. James Peterson and staff of the Washington Division of Medical Assistance; Ms. Faye Powell, Virginia Medical Assistance Program; Ms. Norma Grady and staff of the North Carolina Department of Human Resources; and staff of the Minnesota Bureau of Surveillance and Utilization Review. In addition, appreciation is also expressed for the invaluable input received from several firms in the private sector.

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MANAGEMENT INFORMATION SYSTEM

GENERAL SYSTEMS DESIGN

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INTRODUCTION

A. GENERAL

The General Systems Design (GSD) for the updated Surveillance and Utilization Review Subsystem (S/URS) of the Medicaid Management Information System (MMIS) is a product of the Division of Systems Planning and Development (DSPD), Office of Methods and Systems (OMS), Bureau of Program Operations (BPO), Health Care Financing Administration (HCFA). This GSD is being issued to reflect operational changes in the Surveillance and Utilization Review environment, in new systems technology, and in the provision of Public Law 96-398 (The Schweiker Amendment) to periodically update the MMIS.

Moreover, Public Law 97-35, the Omnibus Budget Reconciliation Act of 1981, provides for an offset in the reduced Medicaid payments for States meeting general Medicaid expenditure targets. The target area which relates to S/URS is fraud and abuse control. Information generated by the system can be used to point out possible instances of such misuse for subsequent case development activity, administrative findings and legal actions to determine a dollar value in savings. This amount is used separately or with section 17 unit figures and TPL recoveries and diversions for the purpose of meeting the requirements of section 2161 of the Act.

The General Systems Design (GSD) is comprised of an introduction, a management overview or executive brief, six sections describing individual subsystems within the Model System, and an Appendix. This material has been grouped for convenience of handling into six volumes.

B. DOCUMENTATION ORGANIZATION

The GSD documentation for each of the six subsystems that make up the Model System is presented within its respective section as follows:

1. Subsystem summary, where the subsystem objectives are itemized and a general description of the subsystem is provided.

2. Design elements, where all assumptions and constraints imposed are listed, where considerations affecting the design of the subsystem are discussed, and where controls and audit trails established to ensure subsystem integrity are listed.

3. Processing flow, where a detailed description is furnished of how each module functions within the subsystem. The GSD for S/URS has eliminated this feature. A functional processing technique for development of either a "Blue Book" or a data base system has been provided.

4. Subsystem outputs, where each major output is defined as to purpose, distribution, content, and format.

5. Subsystem inputs, where each major input is defined as to use, source, and data element content. This section is dropped in the 1982 S/URS.

6. Subsystem files, where each major file is defined as to function and data element content. The GSD for S/URS does not contain a subsystem file section.

7. Input/Output matrix, where data elements used in a subsystem are identified as to their source and distribution. The input/output matrix is left to the option of the User, however the GSD for S/URS contains an output section which describes the general reporting requirements for S/URS.

Volume V - The Appendix contains the following General Systems Design documentation:

1. A glossary which indicates the specialized meaning of various terms used in the design documentation.

2. Data element definitions which provide an explanation of each data element, and where applicable, a recommended code structure.

C. FLOWCHART SYMBOL EXPLANATION

In certain portions of the MMIS GSD documentation, flowcharts are used to graphically describe the processing flow. Such flowcharts are not required in this document.

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SECTION VI

SURVEILLANCE AND UTILIZATION REVIEW SUBSYSTEM

SECTION VI

SURVEILLANCE AND UTILIZATION REVIEW

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A. SUBSYSTEM SUMMARY

VI. SURVEILLANCE AND UTILIZATION REVIEW SUBSYSTEM

A. SUBSYSTEM SUMMARY

1. Overview

The Surveillance and Utilization Review Subsystem (S/URS) is one part of the management information reporting capability of the MMIS. As such, the information generated from the subsystem needs to be focused, summarized, flexible and concise. The information should be able to assist management in providing answers to such questions as:

- What program policies should be implemented, modified or deleted;
- What is the extent of program utilization;
- What is the utilization pattern in relation to cost and norms of care;
- Which participants misuse the program;
- How efficient is the claims processing system; and
- What kind of impact does the program have on its participant community?

S/URS is capable of providing reports and data to support these present and future needs of the user community. To achieve this end, it is incumbent upon managers to ensure that S/URS is operated in a cost effective and systems efficient manner. This document provides the flexibility for managers to implement an operationally efficient S/URS.

2. Objectives

The goal of the Surveillance and Utilization Review Subsystem (S/URS) is to provide a manageable approach to the process of aggregating and presenting medical care and service delivery data to meet two major concerns:

- Surveillance--The process of monitoring the delivery and utilization of covered services and items by Medicaid participants. Surveillance includes use of itemized data for overall program management and use of statistics to establish norms of care in order to detect improper or illegal utilization practices.
- Utilization Review--The process of analyzing and evaluating the delivery and utilization of apparently aberrant medical care on a case basis to safeguard quality of care and to guard against fraudulent or abusive use of the Medicaid program by either persons and/or institutions providing services or persons receiving them.

The Surveillance and Utilization Review Subsystem is a statistical review system that is retrospective to claims processing developed to meet the following primary objectives:

- Provide a profile of health care providers and recipients through which the quality, quantity, and/or timeliness of services can be identified, assessed, and used to establish norms and to identify exceptions to norms;
- Provide continuous interrelated statistics in concert with MARS to show how the total health care delivery system and its individual parts are meeting program objectives;
- Aid management in the process of ensuring that only medically necessary covered services and items (including prescribed drugs) are provided in the appropriate setting at the lowest cost;
- Assist in protecting Medicaid participants against the occurrence of over-utilization and underutilization of health care services by providing support for the following processes:
  - An ongoing educational activity covering the appropriate use and delivery of health care services within the community;
  - Referring providers, whose practices are suspect, to an appropriate medical component for review;
  - Initiating administrative actions to curtail aberrant behavior;
  - Referring potential fraud cases to the Fraud Control unit or function; and
  - Referring recipients to appropriate utilization programs for restricting and/or monitoring within the constraints of current regulations.
- Provide required support for the Medicaid Fraud Control units or functions, as may be appropriate;
- Provide selective medical care data to monitor PSRO activities and to assess quality of care in the absence of PSROs;
- Provide a basis for conducting medical/fiscal reviews to verify that covered health care services have been documented and that payments have been made in accordance with State and Federal policies, regulations, and statutes; and
- Provide management with information to assist in overall program direction, supervision, and policy making.

3. Functions

The principal functions performed in S/URS are as follows:

- Develop comprehensive statistical profiles for revealing utilization patterns of heath care delivery in the various category of services authorized under the Medicaid program;
- Reveal probable instances of fraud and abuse by individual providers and recipients which will promote correction of such misutilization, and
- Provide information indicating the existence of any potential deficiency or excess in the quantity and quality of service provided under the Medicaid program.

4. General Description

The Surveillance and Utilization Review (S/UR) Subsystem is a powerful and flexible tool. It has two primary purposes: 1) to process information on medical and health care services to guide Medicaid program managers and 2) to identify the providers and recipients most likely to be making abusive or allegedly fraudulent use of the Medicaid program. S/UR identifies providers with aberrant patterns of practice and recipients whose use of Medicaid services is questionable. S/UR also makes available data which is used by analysts to establish whether the apparent misuse of the program is real. It is an exception-based, post-payment review process which facilitates corrective action. It enables S/UR analysts to concentrate utilization review efforts on the relatively few participants most likely to be causing a hemorrage of improper expenditures for Medicaid services.

S/UR staff can choose from a large amount of data available the items they want processed. Further, they decide which items will be used to facilitate the review activity and which will be used for exception processing. These decisions require substantial knowledge of medical and health care content and about the organization and delivery of these services.

Providers and recipients with like characteristics are grouped together. The data available about them is broken down into relatively discrete segments called line items.

The activity of each participant with respect to each of theline items is added together. Statistical computations to total each of the line items and to calculate averages and standard deviations are accomplished. These computations are used to establish ranges of exceptional behavior and to define exceptional behavior. Then the experience of each individual participant is compared against exception limits. All participants who exceed exception limits are listed and a profile report summarizing the activity of each becomes available. Reports containing detailed information are available on request.

The S/UR concept is simple, the execution is difficult. S/UR is an automated system, but it does not work automatically. The S/UR staff define and select data, and make decisions on report content and format. The profiles produced establish exceptional behavior by providers and recipients. But exceptional does not necessarily mean culpable. The profiles are meant to be the starting point of an analysis process with other S/UR reports providing information to aid the analysis. The results of the analysis can vary from a finding that the exceptional case was fully justified, even exemplary to a situation of alleged fraud requiring immediate referral to law enforcement authorities. Often there will be a determination that abuse, in one or more of its many forms, has occurred and that corrective action is necessary.

B. DESIGN ELEMENTS

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The design elements for S/URS have been separated into primary and secondary categories, where primary considerations contain minimally required features and secondary considerations contain a group of options. Additional considerations are not precluded and should be addressed during the early phase of the design effort.

1. Design Constraints and Assumptions

This subsystem is largely constrained by the nature of information made available to it through the vehicle of adjudicated claims. The existence of the Model System Claims Processing, Provider, and Recipient Subsystems or their equivalents are assumed. It is also assumed that claims will not be forced through prepayment edits in claims processing (forced or override codes cause data distortion). This will assure the integrity of the S/URS data base.

2. Statement of Requirement

a. The Surveillance and Utilization Review Subsystem is a flexible management tool which can help identify patterns of inappropriate care and services. The screening function of S/URS is implemented through an automated exception processing technique. Conceptually, the exception processing technique requires the following major steps to be performed by the computer system:

- Develop statistical profiles summarizing information contained in paid claims submitted by each individual and institutional provider over a specified period of time. Each profile will consist of a number of statistical indicators which relate to services rendered or received and which include the cost of those services;

- Classify providers and recipients into class groups of peers for the purpose of developing statistical profiles;

- Compute averages and standard deviations by class group for each indicator contained within each statistical profile. Only those individuals with indicators where the activity does not contain a zero value are taken into consideration for these computations;

- Establish norm and exception criteria values by class group for each indicator in the statistical profile from averages and standard deviations computed in the previous step and/or from user specified exception criteria which can override a systems generated norm;

- Evaluate the statistical profiles of all individual providers or recipients within each class group (indicator by indicator) against the matching exception criteria established by user groups for each class group; and

- Print out for manual review a ranking of providers and recipients who were found to be exceptional. At this point, the Medicaid activity for each individual provider and recipient has been evaluated against the mean activity of the group of his peers and is presented for further investigation only if the exception parameters have been surpassed.

b. The functions of peer group classifications and establishment of group norms are statistically determined in the early stages of the system's installation. After the system has been stabilized and tailored to fit the particular circumstances of its user, adjustments can be made to compensate for further changes in the Medicaid environment.

c. The scope of the S/URS activity is completed with the following additional functions which are based on information developed by the exception reporting process:

- Investigate suspected misutilization by examination of adjudicated claim histories and remittance notices sometimes followed by desk audits, field audits, and peer review;

- Produce a permanent microform (e.g., film, fiche) of the periodic profiles of excepted participants. From this microform record, up-to-date and historical information may be obtained on any Medicaid participant for whatever uses may be required;

- Determine actual aberrant utilization;

- Evaluate aberrancies to determine if fraudulent conditions exist;

- Initiate actions to close identified loopholes in the computer system, policy issuances, rules, and regulations so as to prevent further misutilization within the program; and

- Initiate appropriate corrective action against actual abusers according to the nature of their abusive activities and practices.

d. In summary, the computer can assist in the manual functions of investigation and follow-up action to isolate and highlight the small number of misutilizers from the thousands of Medicaid participants. The S/URS maintains participant information and all essential data from adjudicated claims to accomplish this primary goal. The claims data may be selected and printed, at the request of the user, in such a way that only information which is of value in making a determination of misutilization is displayed for the user.

At a minimum, S/URS must include:

- the capability to perform exception processing as identified above;

- a parameter driven control file feature which permits redefining of matrix items;

- 9 months of adjudicated claims data for the S/URS history file, of which, 6 months of data or more must be used for exception processing (excluding the most recent incomplete current quarter);

- a flexible weighting and ranking system of potential exceptional data;

- the capability to identify specific factors contributing to the exceptions noted;

- a random number generator for scientific sampling of claim details;

- the capability to generate reports on the top 20 diagnoses;

- the capability to generate reports on the top 25 procedures;

- the capability to generate reports with English descriptions of codes;

- the flexibility to produce claim detail reports by provider and recipient within the following categories:

  1) procedure,
  2) diagnosis,
  3) drugs,
  4) provider specialty,
  5) provider type,
  6) date(s) of service,
  7) category of service, (COS)
  8) place of service
  9) aid category, and
  10) any combination of the above.

- the capability to suppress calculations and printing of zero and low volume activity;

- the capability to produce microform output;

- a report writer/generator to produce special reports;

- the capability to break out federally assisted program participants from any others in the system;

- the capability to include generic drug class listings as well as therapeutic drug groups;

- an in-depth technical and user training program;

- the capability to generate S/URS reports quarterly and special reports as required;

- the production of Treatment Analysis reports;

- the production of Severity Index reports and Parameter Control reports;
- the capability to profile group practices and to profile each individual in the group practice;
- the capability to suppress processing on individuals within a category of service or class group on a run to run basis;
- the capability to perform focused reviews. However, an annual run of all data on the data base is required;
- the capability to generate frequency distributions on any report item;
- the capability to eliminate from exception processing those participants whose volume of activity for the reporting period is too low for meaningful utilization review;
- the ability to suspend and terminate program abusers.

3. Design Options

A variety of options may be selected to enhance the operation of S/URS. These options will vary according to the special needs of the individual State and type of system installed. The intent of this section is to identify a limited number of these features for consideration based purely on a cost and needs analysis during phase I of the systems design activity.

These considerations include the following:

- An automated case/audit management feature;

  A justification of systems efficiency based on caseload burden should determine if this feature will be included.

- An interactive on-line access capability for the control file;

  When this option is selected, users can quickly isolate a problem and request additional supporting information. The data can be requested on-line and generated in a hard copy form. The on-line feature could also include editing, error correction, and parameter changes options. When selected, this feature eliminates the usual delays caused by form preparation, data entry, validation, and scheduling of runs.

- A Data Base Design

  The major advantage of this design option, particularly when coupled with an on-line capability, is that it provides an improved response time factor for reflecting managerial and programmatic changes. The data base can be

rapidly accessed for redefining and generating output in either on line (real time) or batch mode. The feature also opens up the possibility for considering the production of both MARS and S/URS reports from the same data base.

- The capability to do systematic, random sampling of paid claims to provide a basis for recovering funds based on extrapolations from the sample.
- The capability to limit passing of the history file for production of major reports;
- The capability to generate exceptions on percentiles;
- The capability to generate histograms from frequency distribution data;
- The capability to identify the exceptional provider or recipient on a specific report item;
- The inclusion of General Assistance and Other State only medical care data;

  When State only data is included in S/URS, it must be separately identified.
- A provision for system intervention prior to profile production; at this point the exception review log, ranking exceptions by severity, is generated and reviewed for use in selecting a percentage or specific number of profiles for printing;
- The capability to accumulate totals, compute averages and generate reports on drug data usage for recipients in Long Term Care (LTC) facilities for comparative analyses;
- The production of LTC reports;
- The production of hospital reports when a PSRO is operational and when the PSRO monitoring plan does not mention S/URS reports;
- The addition of Medicare data to provide a basis for an integrated utilization review of persons eligible for both programs;
- The capability to perform MERS type screening functions; and
- The flexibility to vary time periods for reporting purposes.

4. System Controls

   a. Parameter Control Function

      At a minimum, this function should permit the user to easily modify the system. The parameter control feature should include the capability for redefining report items and facilitates criteria setting by providing on a run to run basis for:

- The capability to select claim form data elements from the S/UR history file for exception processing;
- The capability to select any item on provider and recipient records from summary data;
- The capability to group all providers and recipients into homogeneous class groups;
- The capability to select specific diagnoses, procedures, and drugs;
- The capability to specify frequency distribution (and trend reporting if used -a trend line is not required);
- The capability to specify limits for exception reporting for any report item;
- The capability to specify ranges of procedures, diagnoses, and drug code groups;
- The capability to make alterations to data matrix items, reporting periods, and class groups;
- The capability to produce a change listing resulting from new or altered parameters, each time a control file is updated;
- The capability to limit the volume of data generated by the system; and
- The capability to weight specific report items.

b. Exception Processing Function

The exception process consists of the activities necessary to identify and report aberrancies. Within this context, the process includes:

- The capability to allow selections by category of service;
- The capability to request information from another category of service other than the one for which the matrix was created (example: ordered or referred services);
- The development of Class Group profiles;
- The definition of computations for standard deviations, absolute values or other weighting and ranking processes;
- The definition of computations for upper and lower limits;

- The capability to define other statistical computations;
- The capability to override systems generated computations and/or limits;
- The capability to print computations on applicable reports;
- The comparison of excepted line items of individuals against the activity of the appropriate group; and
- The comparison of report items of an individual profile against upper and lower limits.

Once the initial system has been installed and stabilized, the exception processing function executes ongoing and special commands for redefining, sorting, sequencing, and generating recurring and special reports.

c. Weighting and Ranking

The number of exceptional situations revealed by S/UR processing must be made manageable. One means of doing this is development of weighting and ranking techniques. These techniques can be used to reduce, absolutely, the number of exceptions produced and to select the most promising exceptions for first consideration. Weighting and ranking in S/URS has taken two different forms, neither of which has been thoroughly assessed. (Others may be equally as good or better.)

One approach is to seek the most deviant participants regardless of the reasons, and to rank them in order. Consequently, the most deviant participant could achieve his score for entirely different reasons than the one with the next highest score. When this approach is used, calculations of deviance are applied to many report items and to many time periods.

The other approach is to select, in advance, known or suspected problems of utilization. Thus if the concern was misuse of sedative drugs by recipients, a few pertinent report items would be selected for exception processing. For example:

1) persons who saw four or more physicians in a quarter
2) persons who received 16 or more sedative prescriptions in a quarter
3) persons who received sedative prescriptions from three or more pharmacies in a quarter.

Before an individual was considered exceptional, he would need to surpass two of the above limits. These few items would reveal a number of different patterns of sedative abuse.

The purpose of this discussion of weighting and ranking is not to determine which approach is superior. The point is that there must be a mechanism to

produce a manageable number of profiles and to assist the user in setting priorities. Overwhelming users with an unmanageable number of exceptions must be avoided. Properly functioning weighting and ranking mechanisms achieve this end.

d. Data Elements

S/URS functions are performed by using data elements captured from paid claims and provider and recipient enrollment forms. The presence (or absence) of certain data will either facilitate or restrict the ability of the system to function in the most efficient manner. The data which must be present in the system should answer the following questions:

1. Who performed the service or provided the item?
2. Who received the service or item?
3. What service or item was provided or furnished?
4. How many items or services were provided or furnished?
5. Why was the service or item needed?
6. When was the service or item provided?
7. Where was the service or item provided?
8. What was the cost of providing the service or item?
9. Who requested the service or item?

At a minimum, the data element sets which must be present to support S/URS include:

- The Provider Data Element Set;
- The Recipient Data Element Set;
- The Claim Data Set; and
- The data elements identified in the 700 section of the Glossary, Volume V of the General Systems Design, and any other data as may be required for a reference file and to support the Uniform Hospital Discharge Data Set, should be used as applicable.

Minimum components of the data element sets are listed below.

1. Provider Data Element Set

Provider Name
Provider Identification Number (Individual and Group)
Provider Specialty (includes board certified)
Provider Type (includes practice)
Provider Size (includes facility and group practice)

2. Recipient Data Element Set

Recipient Name
Recipient Identification Number
Recipient Age/Date of Birth
Recipient Sex
Patient Status
Recipient Location*
Aid Category*
Recipient TPL (all including Medicare and HMOs as applicable)

Provider Location
Provider Category of Service

Recipient Eligibility

*May be included as part of the Recipient Identification Number.

3. Claim Data Set

Recipient I.D.
Provider I.D.
Transaction Control Number
Attending Physician No.
Prescribing Physician No.
Referring Physician No.
Primary Diagnosis Code
Secondary Diagnosis Code
Admission Date
Discharge Date
Beginning Date of Service
Ending Date of Service
Procedure Code
Drug Code
Date of Surgery
Prescription No.
Days Supply (maximum, minimum)
Drug Classification (Generic/Therapeutic Class)
Charge/Payment Data (includes ancillary)
Payment Date
Place of Service
Units of Service
Type of Service
Date of Service
Recipient Age
Recipient Sex
Indicators:

1. EPSDT
2. Family Planning
3. Adjusted Claim
4. Interim Claim

e. Audit Trails

All parameters established for the system should be edited for accuracy, completeness, and logical interrelationships prior to updating the control file.

A record of all changes, updates, control totals, processing dates, and file identifications shall be maintained. This audit trail record will be available for review in accordance with applicable policy.

f. Maintenance and Security

Maintenance and updating for generating recurring and special reports should be accomplished on an as needed and systems efficient basis. Security/privacy features should be developed for optimum effectiveness of the S/UR subsystem matrix and should include the following areas:

1. Control of data administration
2. Identification of terminals and terminal users
3. Internal relationships
4. Security logs
5. Encrytion
6. Physical
7. Disaster

C. SUBSYSTEM OUTPUTS

C. SUBSYSTEM OUTPUTS

Reports

Reports discussed in this chapter are generated by the S/URS as four major sets of routine reports together with the special reporting capability. The major groups of reports which must be produced by the system include:

1. Management Summary Reports
2. Profile Reports
3. Supporting Reports
4. Other reports

The following sections of this chapter will provide a general description of each of these sets of reports.

1. Management Summary Reports

   Management Summary Reports are produced for each class group and report item to support the analysis process employed in the production of Profile Reports. This analysis process requires the development of norms of care against which each individual participant may be evaluated. Norms are automatically developed by classifying participants into peer groups, computing an average and standard deviation on statistical indicators by peer group, and then establishing a "normal" range of indicator values as the average of the indicator plus and minus a predetermined number of standard deviations from the average. Statistical indicators within Profile Reports will have a norm, or range of acceptable values, developed for it automatically in this fashion. In recognition of the fact that this method will not always produce valid results, the basic statistics from which the norms are computed are printed out in Management Summary Reports to facilitate adjustment of the norms. Users also have the ability to establish criteria to override norms. (Volume indicators may be excepted from this process.)

   These reports are used for Medicaid program management purposes since they contain more specific service and cost data than is available from Management and Administrative Reporting Subsystem Reports.

   A. Frequency Distribution Reports

      Frequency Distribution Reports can be produced for providers and recipients for any report item that appears in the Management Summary Reports. Frequency Distributions are generally printed for the most recent time periods for which data is complete. These reports show the number of providers or recipients who had a particular characteristic of interest to the user.

B. Totals

Summary field totals must be reported by class group and reflect the accumulated totals for each statistical indicator. Totals may be included as a section on existing reports or generated as separate reports.

2. Profile Reports

Profile Reports are the primary tool provided by S/URS for the detection of potential exceptional utilization of the Medicaid program. These reports present, for each individual Medicaid participant, an interrelated set of statistical indicators to reveal exceptional patterns of care. Information contained in these reports is subjected to automated comparison so that only those participants who present a strong probability of requiring investigation for exceptional utilization are reported.

The basic format is the same for all Profile Reports. However, information content (statistical indicators) varies between providers and recipients and, for providers, according to category of service. All information presented is summarized at the participant level from detailed data contained in adjudicated claims, and consists of various unduplicated counts, service counts, and dollar accumulations together with appropriate ratios, averages, and percentages computed therefrom.

Profile Reports provide a picture of the utilization patterns of individual Medicaid providers and recipients. Items of information contained in these reports are selected, by category of service, to reveal common types of exceptional utilization subject to detection by statistical reporting techniques. These reports are used as a screening mechanism to isolate those few participants who appear to be exceptional utilizers of the Medicaid program. For those suspected exceptional utilizers the specific area(s) of exception utilization is indicated to facilitate further investigation.

Generating reports by diagnoses (i.e., reporting on providers' diagnosis/ treatment interrelationships) will either be included as part of profile reporting or presented in a separate report.

3. Supporting Reports

A. Claim Detail Reports

Claim Detail Reports will be produced on a request basis to support the investigation of exceptional utilization by individual Medicaid participants as indicated by Management Summary and Profile Reports. These reports present, for user specified participants, a listing of essential data from each claim paid with a date of service within the appropriate time period.

For each participant, claim detail reports may be printed according to dates of service, procedure code, drug code, diagnosis code, and category of service.

B. Special Reports

Special Reports may be requested from the S/UR Subsystem in order to satisfy requirements for certain information which is obtainable from paid claims but is not covered by standard reports. In order to request special reports, the user must specify what information is to be selected and in what format it is to be printed. The system selects paid claims, extracts data therefrom, does computations on the extracted data, and then prints the final results under the control of the user specified parameters and by the report generator.

4. Other Reports

This group of reports is available to facilitate production of the primary reports used in the analysis and investigation processes. The Severity Index Report and the Parameter Control Report are deemed necessary however other reports may be produced as appropriate.

A. Severity Index Report

This report reflects the extent program participants deviated from their peers. An index or list is produced in descending order of the severity score calculated for each participant who exceeded the exception limits. The index shows those participants who require further review. This report is utilized to determine the participants on whom individual profile reports should be produced. (See page VI-11.)

B. Parameter Control Report

This report or listing answers the question related to what information is available in S/URS. The report contains the definition of items, rules for computations, and a record of changes made in the system.

5. Report Frequency

S/URS reports are generated at the end of each calendar quarter to reflect the most complete and current paid claim activity. Claim detail reports and special reports may be requested at other times by utilizing the full range of reporting options in the basic system design.

6. Data and Report Usage

All pertinent data from S/URS must be reviewed before an apparently exceptional situation is investigated. The review process will aid in determining whether the norms used for the reports are reasonable as well as eliminate from follow-up activities those situations which are explainable when all data is considered.

There are many functions which may be supported and many activities which may be investigated using S/URS data and reports. However, in this section a minimum number of these activities are identified for possible support by S/URS data:

A. Abuse control;
B. Drug utilization review;
C. Fraud control;
D. PSRO monitoring;
E. Recipient restrictions.

Corrective or follow-up action completes the S/URS report usage activity. This activity includes:

A. Administrative actions;
B. Education;
C. Management controls;
D. Recoupment;
E. Referral, including prepayment claims review;
F. Restriction;
G. Reporting.

A. Administrative Actions

The scope and degree of support for administrative actions is dependent upon the individual State's requirements and these should include the ability to suspend and terminate program abusers as identified and substantiated through S/URS reports.

B. Education

S/UR data and reports may be used in a variety of educational activities involving a wide spectrum of topics, audiences, and potential opportunities. Individual participants can be helped to understand their pattern of misutilization within the program; medical societies and associations can be made aware of the possibilities for selective review and evaluation of medical care data; and outputs may be used in continuing education programs to acquaint potential Medicaid practitioners with the range of data available through the system.

C. Management Controls

S/URS data supports medical and fiscal audits and other monitoring and case accountability activities. In such instances, the data is used to verify that payments for health care services were made in accordance with State and Federal policies, regulations, and statutes.

D. Recoupment

S/URS data is designed to reflect total medical expenditures made on behalf of the Medicaid recipient. As such, this data is available to support recoupment activities upon a determination that such funds were erroneously expended.

E. Referral

As individual cases are developed from exceptions generated by the system, a possible fraudulent situation may be identified. In such cases, a referral will be made to the Medicaid Fraud Control Unit (Section 17) for appropriate followup. Other referrals are made to PSROs and State licensure boards, if necessary.

F. Restriction

S/URS data is used to identify the potential candidate for restriction and as a tool to ensure continued adherence to program requirements as a follow-up activity.

G. Reporting

Special and routine reports may be produced to support requirements for periodic and ad hoc data.

7. Staffing

The effective use of S/UR reports is predicated upon the existence of an adequate staff to handle the workload generated by the system. The General Accounting Office has recognized and documented this potential problem in its 1978 report on "Attainable Benefits of the Medicaid Management Information System are not Being Realized."

> "S/UR reports by themselves neither prove fraud or abuse nor do they prove the existence of defects in the level of care or quality of service; they present data that reveals the possible existence of these situations. Therefore, it is important that States have adequate and qualified staffs to both interpret the statistical data generated on S/UR reports and to investigate the resulting suspected providers or recipients."

Since 1978, the deficiencies noted in the staffing of S/UR units have continued. A 1982 report entitled "Medicaid Fraud: A Case Study in Failure of State Enforcement" which is a staff study by the Select Committee on aging of the House of Representatives contains the following paragraph on page 95,

> "GAO expressed particular concern about failure of States to have surveillance and utilization review (S/UR) subsystems of MMIS operable. This is the subsystem which GAO says distinguishes MMIS from an ordinary good claims processing system. The sophisticated computer checks can

help identify aberrant billings which may be indicative of fraud. GAO said the S/UR systems it examined were totally ineffective. Even when States made an attempt to use them, the result was a large pile of computer printouts which were not analyzed for lack of manpower."

The recent development of system performance standards also addresses the need for a Federal mechanism to both measure performance and assess minimal performance levels. The basic purpose of the Systems Performance Review (SPR) program for MMIS is to improve the effectiveness and efficiency of the Medicaid program on an individual State basis as well as for the program overall. The approach in evaluating performance is based on the concept that an MMIS must meet specifically designated functional requirements, as well as certain performance standards. Failure to meet the standards could result in a reduced Federal payment to States.

It is in the area of performance that S/UR staffing is important, both in limiting the report output to a manageable level and in utilizing reports and data within the context of an established performance standard. It follows then, that the SPR presupposes a S/UR staff complement which is equal to the level of effort required to accomplish S/UR functions.

In addition, the recent amendment to Section 1903 1/ makes available offsetting of expenditure reductions for States pursuing fraud and abuse activities. Here again, S/UR staffing can play a key role in determining whether such funding will be affected in a positive manner.

In summary, the provision of the Reconciliation Act of 1981 provides a financial incentive for States to maintain adequate and qualified S/UR staff in support of fraud and abuse control activities. Conversely, the SPR could have a negative impact on States failing to meet S/URS performance standards when acceptable performance is adversely affected by an inadequate staffing level. Thus, an adequate qualified staff is an integral part of the overall S/URS function for effective use of S/URS reports.

1/ See Section 1903(s)(2)(C) of the Social Security Act (Section 2161(a) of the Omnibus Budget Reconciliation Act of 1981, Reduction in Medicaid Payments to States and Offset for Meeting Federal Medicaid Expenditure Targets).

GLOSSARY OF TERMS

GLOSSARY

TERM	DEFINITION
ABUSE	ACTIVITY THAT RESULTS IN THE PROVISION OF EXCESSIVE, UNNECESSARY, INAPPROPRIATE, OR POOR QUALITY CARE TO RECIPIENTS FOR WHICH PAYMENT IS SOUGHT. IT INCLUDES THE CONCEPT OF MISUSE. THAT IS, THE ACTIVITY TO BE PREVENTED IS THE PROVISION OF AND BILLING FOR SUCH SERVICES WHICH, THOUGH NOT FRAUDULENT, DIRECTLY OR INDIRECTLY CAUSES HARM TO PATIENTS OR UNNECESSARY COST TO THE PROGRAM
ACTIVE PROVIDERS (SUBSET)	THOSE PROVIDERS INCLUDED IN THE EXCEPTION PROCESSING ACTIVITY AFTER EXCLUDING THOSE WHO RENDERED AN INSIGNIFICANT NUMBER OF SERVICES DURING THE REPORTING PERIOD
ADJUDICATE	DETERMINING WHETHER A CLAIM IS TO BE PAID, AND BY WHAT AMOUNT, OR DISALLOWED
CATEGORY OF SERVICE (COS)	THE CLASSIFICATION OF MEDICAL SERVICES AUTHORIZED UNDER THE MEDICAID PROGRAM
CLAIM	A BILL RENDERED BY A PROVIDER FOR A PROCEDURE, A SET OF PROCEDURES, OR A SERVICE RENDERED TO A RECIPIENT FOR A GIVEN DIAGNOSIS OR A SET OF RELATED DIAGNOSES
CLAIM DETAIL REPORT	THE CLAIM DETAIL REPORT PROVIDES INFORMATION FROM SELECTED PAID CLAIMS FOR SELECTED PROVIDERS AND RECIPIENTS IN ORDER TO SUPPORT INVESTIGATION OF SUSPECTED MIS-UTILIZERS IDENTIFIED BY SUMMARY PROFILE REPORTS AND /OR TREATMENT ANALYSIS REPORTS. CHARACTERISTICS OF THE CLAIM DETAIL REPORT INCLUDE: (A) THE CLAIM DETAIL REPORT IS AVAILABLE ON REQUEST. (B) PERIODICALLY, ALL CLAIMS PAID TO DATE, ARE ORGANIZED IN PRINT

TERM	DEFINITION
	FORMAT AND RECORDED ON MICROFORM IN ORDER TO PROVIDE A PERMANENT HISTORICAL REFERENCE
CLASS GROUP	CLASSIFYING PARTICIPANTS INTO GROUPS OF THEIR PEERS
DATA ELEMENT	THE BASIC ELEMENT OF INFORMATION THAT CAN BE PROCESSED IN OR PRODUCED BY A COMPUTER
DOCUMENTATION	THE ORDERLY PRESENTATION OF INFORMATION
EDITING	THE REVIEW PROCESS USED TO ACCEPT OR REJECT THE FORM OR FORMAT OF DATA
EXCEPTION REPORTING	THE TECHNIQUE USED TO REPORT ONLY THE INFORMATION WHICH IS ABNORMAL FOR S/UR
FEEDBACK MECHANISM	THE PROCESS WHICH ALLOWS RESULTS FROM S/URS TO UPDATE AND ENHANCE THE PROCESSES OF OTHER MODULES AND, CONVERSELY, ALLOWS THE RESULTS FROM OTHER ACTIVITIES TO UPDATE AND ENHANCE S/URS
FIELD AUDIT	THE ACTIVITY PERFORMED BY OR FOR THE STATE AGENCY TO REVIEW ONSITE A PROVIDER'S RECORDS TO VALIDATE AND/OR ENSURE CONFORMANCE TO MEDICAID STANDARDS
FOCUSED REVIEWS	THE TECHNIQUE FOR IDENTIFYING AND GENERATING REPORTS ONLY FOR A SPECIFIC SERVICE, ITEM, OR PARTICIPANT GROUP FOR THE QUARTERLY ANALYSIS PROCESS

TERM	DEFINITION
FRAUD	MISREPRESENTATION WITH THE INTENT TO OBTAIN SERVICES, MONEY, OR OTHER GAIN TO WHICH ONE IS NOT ENTITLED. FRAUD IS SPECIFICALLY DEFINED BY THE LAWS OF THE APPROPRIATE FEDERAL AND STATE JURISDICTIONS; THE DETERMINATION THAT FRAUD HAS BEEN COMMITTED IS MADE BY A COURT OF LAW
FREQUENCY DISTRIBUTION	ORGANIZATION OF DATA INTO INTERVALS/RANGES OF VALUES WITH A COUNT OF OCCURRENCES OF THE VALUES FOR EACH INTERVAL
HARD CODED	THE PART OF THE SYSTEMS' SOFTWARE PACKAGE WHICH IS INCLUDED IN THE PROGRAM LOGIC AND CODE AND WHICH REQUIRES THE INTERVENTION OF A SKILLED PROGRAMER TO EFFECT CHANGES
INTERACTION	A PROCESS WHICH PERMITS DIRECT COMMUNICATION BETWEEN THE SYSTEM AND THE USER
MEDICAL EXCEPTION REPORTING SYSTEM (MERS)	A COMPUTER SYSTEM DEVELOPED TO DETECT PATTERNS OF FRAUD AND ABUSE AMONG NONINSTITUTIONAL PROVIDERS. IT CONSISTS OF PATTERN SCREENS WHICH FOCUS ON SUCH AREAS AS: "YO-YOING" - EXCESSIVE ENCOUNTERS PROVIDER TO THE SAME RECIPIENT BY ONE PROVIDER; "PING-PONGING" - EXCESSIVE ENCOUNTERS PROVIDED TO A RECIPIENT BY MULTIPLE PROVIDERS; AND "GANG-VISITS" - SERVICE TO A NUMBER OF RECIPIENTS AT A SPECIFIC INSTITUTION AT ONE TIME.

TERM	DEFINITION
MICROFORMS	PHOTOGRAPHIC RECORDS OF PRINTED MATERIAL. THESE RECORDS PROVIDE A REDUCED COPY OF THE ORIGINAL INFORMATION WHICH CAN BE EASILY STORED FOR LATER USE. DIFFERENT MICROFORMS MAY INCLUDE: . MICROFILM, . MICROFICHE, . MICROCOPY, AND . OTHER REDUCING MEDIA
MISUTILIZATION	ANY USAGE OF THE MEDICAID PROGRAM BY A PARTICIPANT NOT IN CONFORMANCE WITH REGULATION AND LAWS (INCLUDES FRAUD, ABUSE, AND DEFECTS IN THE LEVEL AND QUALITY OF CARE).
PARAMETER	A VARIABLE LIMIT THAT IS GIVEN A CONSTANT VALUE FOR A SPECIFIC PURPOSE OR PROCESS; IN S/URS REFERS TO ANY USER DEFINED INTERVENTION
PARTICIPANT	ONE WHO PARTICIPATES IN THE MEDICAID PROGRAM AS A PROVIDER OR A RECIPIENT
PROFILE	AN OUTLINE OF THE MOST OUTSTANDING CHARACTERISTICS OF A VENDOR PRACTICE IN RENDERING HEALTH CARE SERVICES AND RECIPIENT'S USAGE IN RECEIVING HEALTH CARE SERVICES, INCLUDING THE VENDOR'S INDIVIDUAL AND GROUP PRACTICE ACTIVITY
PROVIDER	A PERSON, ORGANIZATION, OR INSTITUTION OFFICIALLY RECOGNIZED AS AN APPROPRIATE SOURCE OF HEALTH, MEDICAL CARE OR SERVICES UNDER A STATE MEDICAL ASSISTANCE PROGRAM. THE PROVIDER MAY ALSO BE IDENTIFIED AS A "PARTICIPANT" IN THE PROGRAM
RECIPIENT	ONE WHO RECEIVED MEDICAID SERVICES. THE RECIPIENT MAY ALSO BE IDENTIFIED AS A "PARTICIPANT" IN THE PROGRAM.

TERM	DEFINITION
RESTRICTION	LIMITING PROVIDER OR RECIPIENT MEDICAID ACTIVITY BECAUSE OF PROGRAM ABUSE.
SAMPLING	A STATISTICALLY VALID TECHNIQUE WHICH IDENTIFIES A SUBSET OF THE WHOLE
TREND	A MEASURE OF THE RATE AT WHICH THE MAGNITUDE OF DATA IS CHANGING.

E. SURVEILLANCE AND UTILIZATION REVIEW SUBSCHEMA DESCRIPTION

E. Surveillance and Utilization Review Subschema Description

Except in one instance, those data elements contained in Part 11 of the State Medical Manual or Volume V of the MMIS-GSD were not redefined.

TITLE XIX MANAGEMENT INFORMATION SYSTEM

GENERAL DESIGN DOCUMENTATION

SUBSCHEMA DESCRIPTION

SUBSYSTEM NAME	SUBSCHEMA NUMBER
SURVEILLANCE AND UTILIZATION REVIEW	
	DATE

ELEMENT CHANGE	MMIS ELEMENT	DATA ELEMENT NAME	MINIMAL	RECOMMENDED
	202	PROVIDER NAME	X	
	103	RECIPIENT NAME	X	
	201	PROVIDER NUMBER	X	
	101	RECIPIENT ID NUMBER	X	
	205	PROVIDER TYPE	X	
	236	PROVIDER LOCATION CODE	X	
	133	RECIPIENT LOCATION CODE	X	
	220	PROVICER SPECIALITY CODE	X	
	232/241	PROVIDER SIZE		X
	109	RECIPIENT AID CATEGORY	X	
	106	RECIPIENT RACE CODE	X	
	107	RECIPIENT SEX CODE	X	
	105	RECIPIENT DATE OF BIRTH	X	
	117	MONEY PAYMENT CODE	X	
	113	THIRD PARTY LIABILITY CODE	X	
	110	ELIGIBILITY BEGIN DATE	X	
	111	ELIGIBILITY END DATE	X	
	301	CATEGORY OF SERVICE	X	
	118	MEDICARE TYPE CODE	X	
	300	TRANSACTION CONTROL NUMBER	X	
	302	TRANSACTION CODE	X	
	304	REFERRING PHYSICIAN NUMBER	X	
	303	ATTENDING PHYSICIAN NUMBER	X	
	306	PRIMARY DIAGNOSIS CODE	X	
	307	SECONDARY DIAGNOSIS CODE	X	
	311	ADMISSION DATE	X	
	312	BEGINNING DATE OF SERVICE	X	
	313	ENDINGING DATE OF SERVICE	X	
	314	PLACE OF SERVICE	X	
	315	REFILL INDICATOR	X	
	316	PATIENT STATUS	X	
	317	DISCHARGE PATITNT'S DESTINATION		X
	322	PROCEDURE CHARGE	X	
	321	TOTAL CLAIM CHARGE	X	

TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION
SUBSCHEMA DESCRIPTION

SUBSYSTEM NAME	SUBSCHEMA NUMBER
SURVEILLANCE AND UTILIZATION REVIEW	
	DATE

ELEMENT CHANGE	MMIS ELEMENT	DATA ELEMENT NAME	MINIMAL	RECOMMENDED
	323	DRUG CHARGE	X	
	327	UNITS OF SERVICE	X	
	305	PRESCRIBING PHYSICIAN NUMBER	X	
	349	PAYMENT AMOUNT	X	
	376	PAYMENT DATE	X	
	378	DATE OF SURGERY	X	
	379	LEAVE DAYS	X	
	386	PRESCRIPTION NUMBER	X	
	380	ALLOWABLE PROCEDURE PAYMENT	X	
	381	PROFESSIONAL FEE	X	
	500	PROCEDURE CODE	X	
	501	DRUG CODE	X	
	503	DAYS OF SUPPLY	X	
*	509	DRUG CLASSIFICATION	X	
	700	PARAMETER TRANSACTION CODE	X	
	701	REPORT GROUP CODE	X	
	702	CLASS GROUP CODE	X	
	703	TYPE GROUP CODE	X	
	704	LOCATION GROUP CODE	X	
	705	SPECIALITY GROUP CODE	X	
	706	AGE GROUP CODE	X	
	707	AID GROUP CODE	X	
	708	REPORT SECTION CODE	X	
	709	REPORT ITEM CODE	X	
	710	DISPLAY INTERVAL CODE		X
	711	ZERO SUPPRESS CODE		X
	712	MONTHLY PROFILE VALUE RANGE	X	
	713	PROFILE MANUAL OVERRIDE CODE	X	
	714	PROFLE EXCEPTION INTERVAL CODE		X
	715	TREND LINE VALUE RANGE	X	
	716	TREND LINE MANUAL OVERRIDE CODE	X	
	717	TREND LINE EXCEPTION INTERVAL CODE		X
	718	FORCE CODE	X	
	719	PROCEDURE/ANCILLARY DISPLAY FREQUENCY		X
	720	PROCEDURE/ANCILLARY DISPLAY INTERVAL CODE		X

TITLE XIX MANAGEMENT INFORMATION SYSTEM

GENERAL DESIGN DOCUMENTATION

SUBSCHEMA DESCRITPION

SUBSYSTEM NAME	SUBSCHEMA NUMBER
SURVEILLANCE AND UTILIZATION REVIEW	
	DATE

ELEMENT CHANGE	MMIS ELEMENT	DATA ELEMENT NAME	MINIMAL	RECOMMENDED
	721	DRUG DISPLAY FREQUENCY LIMIT		X
	722	DRUG DISPLAY INTERVAL CODE		X
	723	TREATMENT REPORT ITEM VALUE RANGE	X	
	724	TREATMENT EXCEPTION INTERVAL CODE		X
	725	EXCEPTION MODE CODE		X
	726	DATA ELEMENT NUMBER	X	
	727	RELATIONAL OPERATOR	X	
	728	RELATIONAL VALUE	X	
	729	LOGICAL CONNECTOR	X	
	730	HEADING SEQUENCE NUMBER	X	
	731	HEADING CONTENT	X	
	732	LEVEL NUMBER	X	
	733	PRINT CONTROL CODE	X	
	734	PSEUDO DATA ELEMENT NUMBER	X	
	735	ARITHMETIC OPERATOR	X	
	736	FIELD WIDTH	X	
	737	START COLUMN	X	
	738	EDIT MASK		X
	739	LITERAL VALUE	X	
	740	RECIPIENT AGE	X	

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM

GENERAL DESIGN DOCUMENTATION

DATA ELEMENT DEFINITION

DATA ELEMENT NAME	DATA ELEMENT NO.
Drug Classification Code	509
ACCEPTABLE SYNONYMS AND ABBREVIATIONS	DATE
	9/29/82

DEFINITION

A code which identifies the category of a particular drug group.

REMARKS

CODE EXPLANATION

CODE	MEANING
A	Therapeutic drug class--classified according to its intended use. Examples of therapeutic groups are antihistamines, tranquilizers, diuretics, etc.
B	Generic drug class--a code which indicates the active therapeutic chemical ingredient(s) of a drug. Examples: Valium would have the generic code for diazepam. Darvon compound would have one generic code for protoxephene and another for aspirin.

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HEALTH CARE FINANCING ADMINISTRATION